MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Ebenezer Management Services	HL28352005	December 28, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
720 Mahtomedi Avenue	8:45 a.m. to 4:45 p.m.	December 26, 2017
Facility City:	**Investigator's Name and Title:**	
Mahtomedi	Kathleen Smith, DNP, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55115	Washington

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when s/he fell and experienced a femur fracture, but the facility did not identify the fracture or send the client for further evaluation until two days later.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect is substantiated. The home care provider was aware the client fell, but failed to provide appropriate assessment, resulting in a two day delay in the diagnoses of a hip fracture.

The client received services from the home care provider for diagnoses that included dementia and osteoporosis. The client had a history of falls and received staff escort services as needed. According to the care plan, the client was ambulatory with a walker to all places. During the six weeks prior to the incident, the client had three falls.

On the date of the incident, the client had a fall, and at that time facial grimacing was observed by the staff. One day after the fall, the progress notes indicated the client was unable to sit on the edge of the bed, was unable to bear weight, and was pale, weak, and sweaty. The client consequently slid to the floor and was noted to have an elevated blood pressure, an irregular heart rate, and an increased breathing rate. The physician was notified, and no new orders were received. Two days after the incident, the client had uneven leg lengths and leg rotation. The client was admitted to the hospital and diagnosed with a fractured hip. There were no other progress notes or assessments documented between the incident and the hospitalization.

The client returned to home care provider. Upon return, the client required a wheelchair and a full body mechanical lift for transportation and transfers. Three months after the incident, the client still required two people to assist with transfers, which was not required prior to the fall.

During an interview, family members stated the client now requires a wheelchair all the time.

During an interview, a nurse for the home care provider stated there was no documentation an assessment of the client was completed after the fall.

The facility had an assessment policy that stated a focused assessment should be completed for incidents such as falls and pain.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The client had a fall and a change in condition after the fall. The home care provider did not monitor and assess the client as required by their own policy.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: None

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Four

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Meals
☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Washington County Attorney

Mahtomedi City Attorney

Washington County Sheriff

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8372

December 19, 2017

Mr. Joe Signore, Administrator
Ebenezer Management Services, Inc
2722 Park Avenue South
Minneapolis, MN 55407

RE: Complaint Number HL28352005

Dear Mr. Signore:

A complaint investigation (#HL28352005) of the Home Care Provider named above was completed on December 19, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Washington County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28352	A. BUILDING: _____ B. WING _____	C 12/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER MANAGEMENT SERVICES, INC	2722 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On December 28, 2016, a complaint investigation was initiated to investigate complaint # HL28352005. At the time of the survey, there were 40 clients receiving services under the comprehensive license. The following correction orders are issued.	0 000		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by:	0 325		

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0 325	Continued From page 1 Based on interview and document review, the licensee failed to ensure a client was free from maltreatment (neglect) when staff failed to assess or monitor the client after a fall, for one of one clients (C1) reviewed. As a result, the client was not sent for further care for two days after a hip fracture occurred. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 started receiving services in June 2012, with diagnoses of dementia, osteoporosis, and back problems. C1 used a walker to assist with mobility. A Fall Risk Assessment dated June 2012, indicated C1 scored a nine, and a score of ten (10) or greater represented high risk. A care plan dated April 2016, indicated C1 used a walker and was to have assistance with ambulation at all times. The Client Monitoring Visit Note dated June 2016, indicated C1 was independent with transfers. A review of progress notes dated October 2016, indicated C1 had falls on July 24, 2016 and August 6, 2016, when her/his knees gave out, and again on August 11, 2016 when his/her knees gave out. Interventions included: C1 was to have staff assistance and use the walker to all places, staff walked side by side with the client, pain medication was adjusted, and the client was placed in a wheelchair due to his/her knees	0 325		

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0 325	Continued From page 2 buckling. According to a facility report dated September 7, 2016 C1 started to shake, became weak, and fell. The client exhibited facial "grimaces/moaning", but there is no other documentation of the location or description of the pain. A nurse was notified and provided instruction to the Unlicensed Personnel (ULP) to take vital signs and observe for injuries. One day after the fall, the progress notes indicated the client was unable to sit on the edge of the bed and therefore slid to the floor. C1 was noted to have an elevated blood pressure, irregular heart rate, and increased respiratory rate at this time. C1's physician was notified, however, there were no orders or additional notes. Two days after the fall, C1 was observed having one leg shorter than the other and externally rotated. C1 was taken to the hospital for evaluation and was diagnosed with a hip fracture. ULP-S stated during an interview on December 28, 2016, at 1:15 p.m., if a client falls and is bleeding or breathing heavy, 911 should be called. For clients who are not speaking, ULP-S stated the client's face should be observed for grimaces and one should listen for noises the client may make. During an interview on December 28, 2016, at 2:07 p.m., ULP-A said if a client falls who is non-verbal, staff should observe for facial grimaces and noises. ULP-A also stated if a shorter leg is observed, leg swelling, if the leg is rotated, or if the foot is flopping, additional follow up is required. During an interview on December 28, 2016, Registered Nurse (RN-D), stated the nurse	0 325		

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0 325	Continued From page 3 should complete a physical assessment and obtain vital signs for the client for three consecutive shifts after a fall and report any changes in condition, bruising, pain, etc. During an interview on December 28, 2016, at 3:15 p.m., RN-T stated the facility did not have a fall policy that indicated what should be done as an assessment, and there was no documentation of any assessment for C1 after the September 2016 fall. A review of the Fall Prevention education training dated 2007, revealed a Fall risk assessment should be completed "after [a] change in physical status". A review of the policy titled 03-003 Initial and On-going Assessment of Clients, revealed a focused assessment should be completed for identified areas such as falls. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 325		
0 860 SS=D	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services.	0 860		

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0 860	Continued From page 4 (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to assess and monitor the client after a fall. This impacted one of one clients (C1) reviewed. This practice resulted in a level three violation (violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 started receiving services in June 2012, with diagnoses of dementia, osteoporosis, and back problems. C1 used a walker to assist with mobility. A Fall	0 860		

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0 860	Continued From page 5 Risk Assessment dated June 2012, indicated C1 scored a nine, and a score of ten (10) or greater represented high risk. A care plan dated April 2016, indicated C1 used a walker and was to have assistance with ambulation at all times. The Client Monitoring Visit Note dated June 2016, indicated C1 was independent with transfers. A review of progress notes dated October 2016, indicated C1 had falls on July 24, 2016 and August 6, 2016, when her/his knees gave out, and again on August 11, 2016 when his/her knees gave out. Interventions included: C1 was to have staff assistance and use the walker to all places, staff walked side by side with the client, pain medication was adjusted, and the client was placed in a wheelchair due to his/her knees buckling. According to a facility report dated September 7, 2016 C1 started to shake, became weak, and fell. The client exhibited facial "grimaces/moaning", but there is no other documentation of the location or description of the pain. A nurse was notified and provided instruction to the Unlicensed Personnel (ULP) to take vital signs and observe for injuries. One day after the fall, the progress notes indicated the client was unable to sit on the edge of the bed and therefore slid to the floor. C1's physician was notified, however, there were no orders or additional notes. Two days after the fall, C1 was observed having one leg shorter than the other and externally rotated. C1 was taken to the hospital for evaluation. ULP-S stated during an interview on December 28, 2016, at 1:15 p.m., if a client falls and is bleeding or breathing heavy, 911 should be called. For clients who are not speaking, ULP-S stated the client's face should be observed for	0 860		

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